

## DEPARTMENT OF HEALTH SERVICES

P.O. BOX 1287

SACRAMENTO, CA 95812-1287



June 25, 1993

TO: All County Welfare Directors  
All County Administrative Officers  
All County Medi-Cal Program Specialists/Liaisons

Letter No: 93-37

SUBJECT: Health Insurance Premium Payment (HIPP)  
Employer Group Health Plan (EGHP)

REFERENCE: All County Welfare Directors Letter 91-94

This is to provide you with information related to the HIPP and EGHP programs.

HIPP

The State is authorized to pay the Medi-Cal beneficiary premium for existing health insurance when it is determined by the State to be cost effective.

EGHP

The State is mandated to identify and enroll Medi-Cal beneficiaries in an available Employer Group Health Plan and pay insurance premiums when it is determined by the State to be cost effective. This program was formerly referred to as OBRA 90 in ACWDL 91-94.

Mandatory Participation in HIPP

Section 50763(a)(1) California Code of Regulations requires that a Medi-Cal beneficiary shall apply for, and/or retain any available health insurance when no cost is involved. When premium payment by HIPP is found to be cost effective and Department of Health Services (DHS) has started premium payments, the county must discontinue Medi-Cal eligibility if the beneficiary terminates enrollment in the HIPP purchased health insurance without DHS's approval. When this situation occurs, DHS will send the beneficiary's county eligibility worker notification (see enclosed form HIPP1) with instructions to give notice and discontinue Medi-Cal eligibility (see enclosed form DHS 6193). Once the beneficiary receives the notice of action from the county, he/she has the right to request a State Hearing regarding the discontinuance of benefits. The State will provide a position statement pertaining to the Department of Health Services' testimony for the State Hearing.

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All County Administrative Officers  
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#### Mandatory Participation in EGHP

The Omnibus Budget Reconciliation Act of 1990 mandates that enrollment in an EGHP when cost effective, is a condition of Medicaid (Medi-Cal) eligibility, except for an individual (such as a child) who is unable to enroll on his/her own behalf. If a Medi-Cal beneficiary fails to cooperate in enrollment in an EGHP, when DHS finds the plan to be cost effective, the county must discontinue the beneficiary's Medi-Cal eligibility, after giving appropriate notice (see enclosed form DHS 6193). Also, when DHS finds enrollment in an EGHP to be cost effective and has started premium payments, the county must discontinue Medi-Cal eligibility if the beneficiary terminates enrollment in the EGHP without DHS's approval. When this situation occurs, DHS will send the beneficiary's county eligibility worker notification (see enclosed form HIPPI) instructing him/her to take action to give notice and discontinue Medi-Cal eligibility (see enclosed form DHS 6193). Once the beneficiary receives the notice of action from the county, he/she has the right to request a State Hearing regarding the discontinuance of benefits. The State will provide a position statement pertaining to the Department of Health Services' testimony for the State Hearing.

#### County Notification to State of Discontinuance in HIPP or EGHP purchased insurance

If the county learns that a Medi-Cal beneficiary has withdrawn from enrollment in a State-paid HIPP or EGHP, notify DHS by calling (916) 323-9602. After disenrollment is verified, DHS will request the county to provide notice and discontinue Medi-Cal eligibility. If a Medi-Cal beneficiary has withdrawn from enrollment in a State-paid HIPP or EGHP and has been discontinued from Medi-Cal, the county should make that individual an ineligible member of the Medi-Cal Family Budget Unit (MFBU).

#### Submission of Health Insurance Questionnaire (DHS 6155) for HIPP Enrollment

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, provides that all employers employing more than twenty (20) persons must offer up to eighteen (18) months (29 months in certain instances) of continuing health coverage for all terminating employees. The employee must, within 60 days of termination or notice from the employer, accept coverage by signing the COBRA election notice and pay necessary premiums. If the COBRA election notice is not returned within the sixty day period or premium payment is not submitted, the employer is under no obligation to provide continuing health coverage.

If a potential HIPP Medi-Cal beneficiary has at least thirty (30) days remaining of the 60 day COBRA enrollment period, the county should immediately send a completed DHS 6155 form to DHS. If fewer than 30 days remain of the period, the county may submit the DHS 6155 form in the usual batch manner, since premium payment will not be pursued.

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Submission of Health Insurance Questionnaire (DHS 6155) for EGHP Enrollment

The submission of the DHS 6155 form for potential EGHP participants does not require the same time frame as HIPP participants. Inasmuch as EGHP eligibles do not have health insurance coverage, but health insurance coverage is available through an employer, there is time to work with the employer to determine scope of coverage of available plan(s), cost effectiveness and secure the necessary documents for review. The county should submit the DHS 6155 form as indicated below.

Where to Submit DHS 6155 for Potential HIPP and EGHP

The DHS 6155 form which identifies potential EGHP and HIPP participants should be identified with the letters "HIPP" or "EGHP" in the upper right hand corner of the form. The forms, so identified, should be placed in a separate envelope from all other DHS 6155 submissions and sent to:

Department of Health Services  
HIPP/EGHP  
P.O. Box 1287  
Sacramento, CA 95812-1287

If you have any questions regarding HIPP or EGHP programs, please contact Mr. Robert Kimball at (916) 323-9588.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief  
Medi-Cal Eligibility Branch

Enclosure(s)

## DEPARTMENT OF HEALTH SERVICES

P.O. BOX 1287

SACRAMENTO, CA 95812-1287



Date \_\_\_\_\_

County \_\_\_\_\_

District Number \_\_\_\_\_

Worker Number \_\_\_\_\_

☐ The Health Insurance Section has enrolled the Medi-Cal beneficiary(ies) listed below in the Health Insurance Premium Payment (HIPP) Program. The beneficiary(ies) cancelled the insurance for which the State has been paying premiums.

☐ The Health Insurance Section has enrolled the Medi-Cal beneficiary(ies) listed below in an Employer Group Health Plan (EGHP). The beneficiary(ies) cancelled the insurance for which the State has been paying premiums.

Enrollment in HIPP/EGHP is a condition of Medi-Cal eligibility; therefore, please notify the beneficiary(ies) (via Notice of Action form DHS 6193) that Medi-Cal eligibility is discontinued in accordance with Section 50179(d)(1) Code of California Regulations.

Medi-Cal Recipient _____	Social Security Number _____
Medi-Cal Recipient _____	Social Security Number _____
Medi-Cal Recipient _____	Social Security Number _____
Medi-Cal Recipient _____	Social Security Number _____

If you have any questions regarding this information, please call the representative shown below.

Health Insurance Representative  
Phone Number: (916) \_\_\_\_\_

HIPP1

**MEDI-CAL  
NOTICE OF ACTION  
DISCONTINUANCE OF BENEFITS  
HIPP - EGHP**

(County Stamp)

Case No: \_\_\_\_\_

District: \_\_\_\_\_

Discontinuance for: \_\_\_\_\_

(Name)

Your Medi-Cal benefits will be discontinued effective the last day of \_\_\_\_\_ because:

- ☐ You failed to cooperate in processing an application for the Health Insurance Premium Payment (HIPP) Program which was determined by the State to be cost effective and for which premiums would be paid by the State at no cost to you.
- ☐ You failed to retain enrollment in the Health Insurance Premium Payment (HIPP) Program which was determined by the State to be cost effective and for which the premiums have been paid by the State at no cost to you.
- ☐ You failed to cooperate in the enrollment of an Employer Group Health Plan (EGHP) which is available to you, was determined by the State to be cost effective and for which premiums would be paid by the State at no cost to you.
- ☐ You failed to retain enrollment in an Employer Group Health Plan (EGHP) which was determined by the State to be cost effective and for which the premiums have been paid by the State at no cost to you.

This action does not affect the Medi-Cal benefits of your spouse and/or children for regular Medi-Cal.

If you have any questions about this action, please contact your Eligibility Worker.

The regulation which requires this action is California Code of Regulations, Title 22, Section 50763(a)(1).

\_\_\_\_\_  
(Eligibility Worker)\_\_\_\_\_  
(Date)( ) \_\_\_\_\_  
(Phone)

PLEASE READ THE BACK FOR YOUR HEARING RIGHTS AND OTHER IMPORTANT INFORMATION

## YOUR HEARING RIGHTS

### To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

### To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

### To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

### To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free: 1-800-952-5253  
If you are deaf and use TDD call: 1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

### Other Information

**Child Support:** The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

**Family Planning:** Your welfare office will give you information when you ask.

**Hearing File:** If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W & I Code Section 10950)

## HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

You may also call 1-800-952-5253.

### HEARING REQUEST

I want a hearing because of an action by the Welfare Department of \_\_\_\_\_ County about my

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal  
☐ Other (list) \_\_\_\_\_

Here's why: \_\_\_\_\_

I will bring this person to the hearing to help me  
(name and address, if known):

I need an interpreter at no cost  
to me. My language or dialect is: \_\_\_\_\_

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

My signature: \_\_\_\_\_

Date: \_\_\_\_\_

**NOTIFICACION DE ACCION  
DE MEDI-CAL  
DESCONTINUACION DE BENEFICIOS  
HIPP - EGHP**

(Sello del Condado)

No. del Caso: \_\_\_\_\_

Distrito: \_\_\_\_\_

Descontinuación para: \_\_\_\_\_

(Nombres)

Se descontinuarán sus beneficios de Medi-Cal a partir del último día de \_\_\_\_\_  
porque:

- ☐ Usted no cooperó en la tramitación de una solicitud para el Programa de Pago de Primas de Seguro de la Salud (HIPP) el cual, el estado determinó que es eficiente en cuestiones de costo, y para el cual, el estado pagaría las primas sin costo para usted.
- ☐ Usted no mantuvo su inscripción en el Programa de Pago de Primas de Seguro de la Salud (HIPP) el cual, el estado determinó que es eficiente en cuestiones de costo, y para el cual, el estado pagaría las primas sin costo para usted.
- ☐ Usted no cooperó con relación a su inscripción en un Plan de la Salud en Grupo Proporcionado por los Patronos (EGHP), que está a la disposición de usted, el cual el estado determinó que es eficiente en cuestiones de costo, y para el cual, el estado pagaría las primas sin costo para usted.
- ☐ Usted no mantuvo su registro o membresía en un Plan de la Salud en Grupo Proporcionado por los Patronos (EGHP), el cual, el estado determinó que es eficiente en cuestiones de costo, y para el cual, el estado pagaría las primas sin costo para usted.

Esta acción no afecta los beneficios de Medi-Cal de su esposa(o) y/o los de sus hijos para Medi-Cal regular.

Si tiene preguntas con relación a esta acción, por favor comuníquese con su Trabajador(a) de elegibilidad.

El ordenamiento que requiere esta acción es la sección 50763(a)(1) del Título 22 del Código de Ordenamientos de California.

(Trabajador de Elegibilidad)

(Fecha)

( )

(Teléfono)

**POR FAVOR LEA EL REVERSO, EL CUAL CONTIENE SUS DERECHOS A UNA AUDIENCIA Y OTRA INFORMACION IMPORTANTE**

Para pedir una audiencia con el estado.

El lado derecho de esta página le indica cómo hacerlo.

- Usted tiene solamente 90 días para solicitar una audiencia.
- Los 90 días comenzarán un día después de la fecha en que le enviamos esta notificación.
- Tiene menos tiempo para pedir una audiencia si desea seguir recibiendo los mismos beneficios.

Debe solicitar una audiencia antes que la acción entre en vigor.

- Su asistencia monetaria permanecerá sin cambios hasta que se lleve a cabo su audiencia.
- Su Medi-Cal permanecerá sin cambios hasta que se lleve a cabo su audiencia.
- Sus estampillas para comida permanecerán sin cambios hasta que se lleve a cabo la audiencia o hasta el fin de su período de certificación; lo que ocurra primero.
- Si la decisión de la audiencia indica que estamos en lo correcto, usted nos deberá cualesquier dinero o estampillas para comida que haya recibido.

**Para que se descontinúen ahora sus beneficios**

Si usted desea que se discontinúen su asistencia monetaria o sus estampillas para comida mientras espera una audiencia, marque uno de los casilleros.

☐ Asistencia monetaria ☐ Estampillas para comida

**Para que le asistan**

Puede obtener información acerca de sus derechos a una audiencia o asesoría legal gratuita llamando al teléfono de información del estado.

Número gratuito 1-800-952-5253  
Si es sordo y usa TDD: 1-800-952-8349

Si no desea venir a la audiencia solo, puede traer un amigo, un abogado o cualquier otra persona, pero usted debe hacer los arreglos para traer a esa otra persona.

Es posible que pueda obtener ayuda legal gratuita en su oficina local de asesoramiento legal (legal aid) o de su grupo de derechos de recipientes de asistencia pública.

### Otra información

**Mantenimiento de hijos:** La oficina del Fiscal del Distrito le ayudará a cobrar mantenimiento de hijos aun cuando no esté recibiendo asistencia monetaria. Esta asistencia es gratuita. Si en la actualidad están cobrando mantenimiento de hijos a su nombre, ellos continuarán haciéndolo hasta que usted les dé aviso por escrito indicándoles que paren. Le enviarán a usted cualesquier cantidades de mantenimiento que cobren. Se quedarán con las cantidades vencidas cobradas que se le deban al condado.

**Planificación familiar:** Su oficina de bienestar le proporcionará información cuando usted la solicite.

**Expediente de la audiencia:** Si usted solicita una audiencia, la oficina de audiencias con el estado formara un expediente. Usted tiene el derecho de examinar este expediente. El Estado puede dar su expediente al departamento de bienestar, al Departamento de Salud y Servicios Humanos de los Estados Unidos y al Departamento de Agricultura de los Estados Unidos. (Sección 10950 del Código de Bienestar e Instituciones)

La mejor manera de solicitar una audiencia es llenar esta pagina y enviarla a:

**Tambien puede llamar al 1-800-952-5253.**

## PETICION PARA UNA AUDIENCIA

Deseo solicitar una audiencia a causa de una acción ejercitada por el Departamento de Bienestar del Condado de \_\_\_\_\_ acerca de mi: \_\_\_\_\_

- ☐ Asistencia monetaria      ☐ Estampillas para Comida  
☐ Medi-Cal  
☐ Otro (anote) \_\_\_\_\_

La razón es la siguiente: \_\_\_\_\_

La siguiente persona vendrá conmigo a la audiencia a ayudarme (nombre y dirección si los sabe):

**Necesito un intérprete sin costo para mí.**

Mi idioma es el: \_\_\_\_\_

**Mi nombre:** \_\_\_\_\_

Dirección:

Teléfono: \_\_\_\_\_

**Mi Firma:** \_\_\_\_\_

Fecha: \_\_\_\_\_